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Domestic violence documentation project 2012

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ABSTRACT

One in four women presenting to Emergency Departments in Australia have experienced domestic violence in their lives but there are no specialist services for victims of domestic violence in the state of New South Wales, population of 7.25 million.

Fundamental forensic medical and nursing skills developed for the comprehensive assessment of complainants of sexual assault were utilised in the examination of victims of domestic violence in a trial project at Nepean Hospital, Sydney. The project was then reviewed via a series of qualitative patient and police interviews along with an analysis of court outcomes. Assessment by specialists in forensic documentation and interpretation of injuries with the provision of balanced expert opinions for court purposes can result in a number of benefits for the victims and the criminal justice system, including an increase in the rate of successful prosecutions.

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"Violence against women is today widely recognised as a global problem. It is one of the least visible but most common forms of violence, and one of the most insidious violations of human rights. It has serious impacts on the health and wellbeing of those affected and exacts significant costs on communities and nations."[1]

1. Introduction/background

Domestic violence is defined, by NSW Health, as a range of violent and abusive behaviours perpetrated by one partner against another. It may occur within the context of marriage, de facto relationships and includes couples who are separated or divorced. The NSW legislation (Crimes (Domestic and Personal Violence) Act 2007) adopts a far wider definition of what constitutes a domestic relationship (section 5) and includes married partners, de facto partners, when there has been an intimate relationship (even if not sexual), when both victim and offender live or have lived in the same household or been long term residents together at a residential facility, been in a carer relationship or part of an extended family as identified by Aboriginal and Torres Strait Islanders. It also applies if the offender and victim are related including in-law relationships, half or step relationships. For the purpose of the study we adopted an inclusion criteria if the offender/victim were or had been in a partnership relationship of any kind or if they were related to each other and living together.

NSW Health has elucidated several aims with regards to domestic violence and these included the reduction of the incidence of domestic violence and the minimisation of the trauma of those people living with it.[2] Their domestic violence policy states that 'one in four women presenting to Emergency Departments in Australia have experienced domestic violence in their lives' yet acknowledges 'there is no specialist service for victims of domestic violence'.[2] This is despite the fact that an Australian survey of women, aged 18–69, who identified as ever having had an intimate male partner found that one third of them had experienced physical violence from their partner in their lifetime (34%).[3]

Assistant Commissioner Mark Murdoch, NSW Police Force corporate spokesperson on domestic and family violence, said NSW police attended 120,000 domestic violence incidents in 2011 – an average of 330 per day.[4]

The cost of violence against women was estimated to have cost the Australian economy $13.6 billion in 2009.[8]

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For every experience of violence to women that can be prevented, over $20,000 in costs can be saved. If current rates of violence to women could be reduced by 10% over the next decade, it is estimated that $1.6 billion in costs could be avoided.[9]

Across the border, in Victoria, intimate partner violence contributes 7.9% to the total disease burden of women aged 18–44 years.[5] This makes it the leading contributor to morbidity and premature mortality in this age group, outstripping other known risk factors such as obesity, smoking, high blood pressure, alcohol and illicit drug use.[5] Women affected by violence require more operations, spend more time visiting doctors and have lengthened hospital stays when compared to women who do not have a history of violence.[6]

> *"While it is clear that ordinary, healthy people may become entrapped in prolonged abusive situations, it is equally clear that after their escape they are no longer ordinary or healthy"*[7]

Domestic violence does not only affect women. It affects men and children. The Australian Bureau of Statistics has estimated that at least 1 million Australian children by 2005 have been personally affected by Domestic Violence.[10]

In the National Crime Prevention Survey, almost one quarter of Australian youth reported witnessing physical domestic violence against their mother.[11]

Some women, unfortunately, pay the ultimate price for such violence. During 2007–2008, of all female homicide victims in Australia, 55% were killed by their male intimate partner.[12]

The forensic medical response to domestic violence has, for the most part, been negligible. NSW is the only Eastern State in Australia that has artificially divided forensic medicine into two disparate categories: (1) forensic medicine applicable to victims of sexual assault and/or child abuse and (2) forensic medicine applicable to other areas (e.g. road traffic medicine, custodial medicine, assistance to the Coroner, assessment and collection of forensic evidence from persons of interest etc.) Victims of domestic violence, for some reason, did not actively fall into either category. They, instead, were sent to busy Emergency Departments or General Practitioners to have injuries treated and documented. The results were that appropriate documentation of injuries rarely occurred, diagrams of injuries were rarely made and photos were usually not collected. In addition, injuries were not interpreted with relation to the likely causation. Furthermore, cases have been hampered by delay in obtaining the necessary medical evidence or by not meeting the standards required by a court for a successful conviction.

2. Pilot project outline

The DV forensic injury documentation service began as a trial project in December 2008 for victims of domestic violence who were in the Nepean Blue Mountains Local Health District (NBMLHD) catchment area. Sydney is divided into 19 local health districts and the NBMLHD is estimated to have a population in excess of 350,000 people, stretching from North West Sydney to beyond the Blue Mountain range. The project was designed as an extension of the core skills of injury interpretation and photo-documentation that were already being used in the assessment of victims of sexual assault. Field forensic photographs have also been shown to be statistically linked to gaining a custodial penalty (odds ratio 4.75) and to the length of the sentence.[15] The domestic violence documentation project sought to address a clear gap in service. It was not intended to replace current documentation undertaken by either police or primary medical health care staff but, rather, to augment this process and ensure high quality standard documentation for the courts. A secondary purpose of the project was to do this within existing resources.

Patients were referred by police from the St Marys and Penrith Local Area Commands (LACs), social workers from Nepean Hospital, staff at Local Courts and Women's Health Centres. The patient contacted the unit and arranged an appointment during business hours at Nepean Hospital's FMU.

Patients were met in the Emergency Department by either the social worker or a member of the medical team and, after being triaged, were escorted to the Forensic Medical Examination room. The process, on average, took just over two hours, considerably less than an average Emergency Department visit.

A full history, including forensic history, was taken and an examination performed. A 'package', with the patient's consent, was prepared for NSW police force. This included:

- History of events as given by the patient.
- Full examination and documentation of injuries.
- Diagrammatical representation of injuries.
- Photographs of images (electronically stored on a DVD).
- Provision of an expert opinion in the form of an Expert Certificate (as required in NSW).
- Attendance at Court as an Expert Witness, if required.

If the patient elected not to release the information to police, the 'package' was kept as part of the patient's medical record and the patient was informed that this could be released at any time in the future, if the patient provided the necessary consent to do so.

On the occasions when social work support was offered (dependent upon available resources) women engaged in the conversations and took the handout material offered. Many also participated in further conversations in relation to referrals and other processes.

The project worked from the understanding that abuse occurs when one person has or attempts to have power over another. With this in mind workers in the project made a conscious decision that when staff interacted with the patient that they offered support and provided opportunities for the patient to take control in the ongoing decision making.

There is some evidence from the literature that prosecution and conviction for domestic violence is associated with reduced recidivism[13] and that empowering court experiences contribute to positive mental health outcomes for victims.[14] However, there was little information available locally concerning how the circumstances of clients of the FMU had changed post-intervention and whether there had been improvements in their own sense of safety.

3. Qualitative review

In late 2011 approval was provided by the NBMLHD Ethics Committee to undertake a comprehensive review of the project.

The aim of the review was to assess the success, or otherwise, of the project and to assist in determining whether the programme should continue, and if so, to identify its potential for ongoing improvement. To this end, the review addressed:

- Whether the project was being delivered as planned.
- Whether there had been any significant difficulties in its implementation.
- The experiences of clients and the subsequent impact of intervention on their sense of safety.
- The perspectives of service providers and referral agents concerning the service provided the benefits it conferred and ways it might be enhanced.

The review also examined project outcomes in terms of conviction rates.

4. Method

The review incorporated both qualitative and quantitative elements in a cross-sectional descriptive design. Data was gathered for the period from the programme's inception in December 2008 until the end of August 2011 utilizing programme records, police data and interviews with clients, service providers and referral agents as well as process mapping exercises with project staff as the principal data sources.

Telephone contact was attempted with all DV patients seen in the nominated time period and patients were asked for consent to participate in the evaluation. They were offered the option of telephone interviews in the first instance by a member of the counselling staff of the Area Health Service's Integrated Violence Prevention and Response Service (IVPRS). This service is independent of the Forensic Medical Unit. Patients were also offered the option of a mailed questionnaire or face to face interview if preferred.

A series of structured face-to-face interviews were conducted with staff from the FMU who provide the service and with local police and police prosecutors. The interviews were conducted by the Community Health Service's research officer who, whilst an employee of the Local Health District (LHD), was not connected to the programme and had no vested interest in the potential outcome.

In addition, programme records and police data were reviewed and summaries prepared. These included client demographics, service utilization patterns, the number and proportion of domestic violence cases accessing the service as well as case dispositions for those who had accessed the service compared with those who had not.

In order to determine court outcomes, case disposition data was extracted from the police's database [Computerised Operational Policing System or COPS] for domestic violence referrals to the FMU covering its first three years of operation [January 2009 to December 2011].

Lastly, staff and police participated in a group exercise facilitated by the research officer in order to map the relationships between the main organisational entities [police, courts and FMU] as well as the key processes that comprise the project's activities. This was a key step in process evaluation designed to clarify programme boundaries, to assess the project's flow of activity and to highlight areas for potential improvement.

Thirty minute interviews were conducted, with police, including prosecutors [$n = 13$] and with FMU members of staff [$n = 2$]. These comprised the forensic medical specialist, who is also the Department Head, and the Unit's registered nurse SANE [Sexual Assault Nurse Examiner]. Thirty five client interviews were also conducted. Detailed notes from the interviews were transcribed and subject to thematic analysis.

5. Results

5.1. Court outcomes

Fig. 1 documents the availability of information from the court outcomes. Whilst there had been 100 referrals to the FMU in that time, court determinations of guilt or otherwise were available for 56 cases.

Comparisons were made with outcomes for cases where, in the same three year period, medicals had been conducted by GPs or the Emergency Department at Nepean Hospital. Police records indicate that there were 63 such cases identified for the Penrith Local Area Command, 56 of which, coincidently, had also been finalised in court. Fig. 2 shows case dispositions by type of medical.

With regard to overall determinations of guilt, the proportion of defendants entering initial guilty pleas were very similar for each group, 38% [21 out of 56] where medicals had been conducted by the FMU and 41% [23 out of 56] for other types of medical. However,

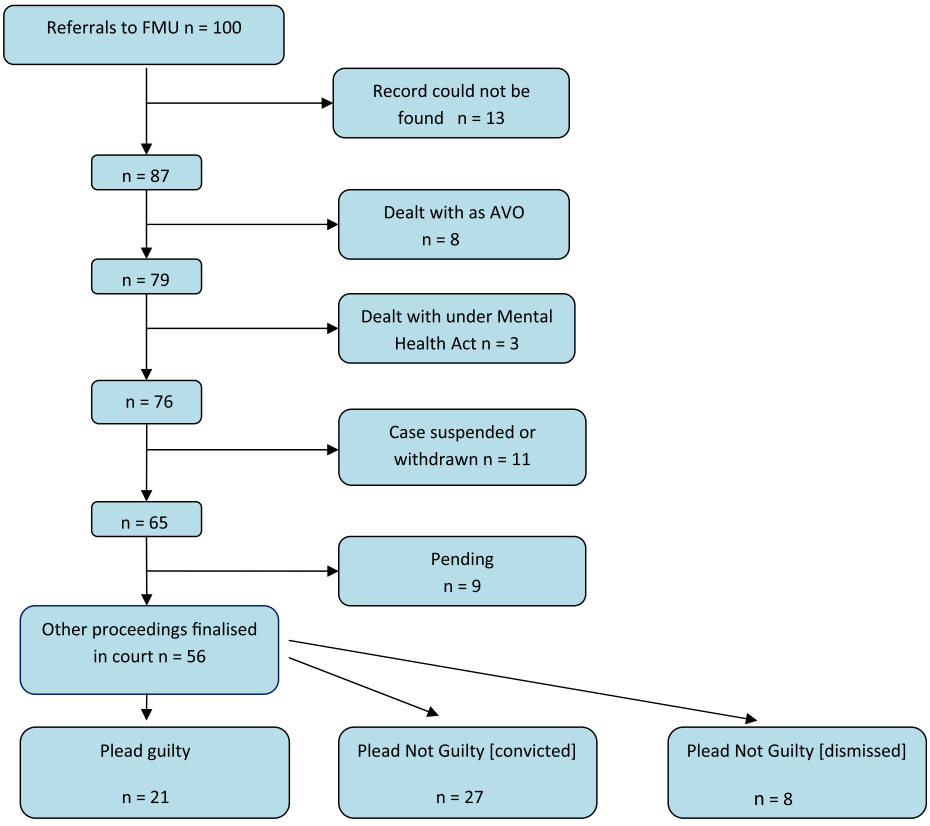

Fig. 1. Availability of court outcome data for referrals to the FMU 2009–2011. Source of information: COPS.

among FMU cases, 86% of defendants were ultimately found to be guilty [48 out of 56 finalised cases; 8 cases dismissed]. The corresponding figure for cases where the medical had been conducted by the ED or GPs in the same period was 71% [40 out of 56 completed cases; 16 cases dismissed]. This trend favoured the FMU, with the difference approaching statistical significance [$\chi^2 = 5.03$, 2 d*f*, $p = 0.0809$].

A comparison was also made of conviction rates among those cases where there had been a 'not guilty' plea. Where the medical had been conducted by the FMU, the conviction rate was 77% [27 out of 35 or 48% of the total sample]. This was substantially higher than the 52% [17 out of 33 or 30% of the total sample] recorded for those cases where the victim's medical had been conducted by GPs or ED. This difference was statistically significant [$\chi^2 = 4.88$, 1 d*f*, $p < 0.03$]. The 95% confidence interval for the obtained difference covered the range of 47.6%–3.6%, favouring the FMU.

Fig. 3 shows the number of domestic violence incidents reported to Police in the Penrith LGA for the three years 2009–2011. The total for the whole period was 2808. Clearly, the proportion of these resulting in a referral to the FMU was quite small [3.5%, $n = 100$].

Year	Number of Incidents	Rate per 100,000
2009	861	466.9
2010	940	504.8
2011	1007	540.8

Fig. 3. Domestic violence incidents for Penrith LGA 2009–2011. Source: NSW Bureau of Crime Statistics and Research.

5.2. Police and prosecutor interviews

Thirteen interviews were conducted with managers, DV Liaison Officers [DVLOs], prosecutors and general duties police, one of whom was relatively new to the role.

It became obvious that the service was well known but decidedly under-utilised. Problems associated with the utilisation of this service included high work volumes, information overload, police staff turnover and the sporadic nature of training which has been constrained by a lack of resources.

Respondents cited the frustration of having victims repeatedly unwilling or unable to take action or else withdrawing from proceedings as well as the perception, by some, that courts do not take DV seriously.

Despite the difficulties, there was a common view that once police had made a referral, their understanding grew rapidly and they were much more likely to utilise the service again.

> *"It's not well understood in depth until it's used or they see what the results are".*

Most officers related direct experiences of either making a referral to the service, or in the case of a manager, of reviewing briefs when victims seek to withdraw from proceedings.

> *"I recall one case where the brief was sufficient to convict without the victim having to give evidence. It comes with an opinion that allows me to make a judgement about whether to proceed. I can base good judgements about whether to proceed based on the FMU's opinion".*

Most respondents had direct experience of making a referral and were extremely positive.

> *"A case went to the FMU – it worked well. It's brilliant; it's useful, evidence-based. The victim was happy. It got me a conviction".*

There was frequent reference to the high quality of the documentation, the timeliness and smoothness of the process and a perception of the increased likelihood that offenders would plead guilty. Some also expressed the opinion that the briefs provided by the FMU were of a higher quality than those available from ED or GPs.

> *"I also had an experience with a GP who didn't know what to do. He said he had done one about 10 years ago – I had to send him an example of a statement".*

All police interviewees clearly thought that the service provided benefits to clients. Among those commonly noted:

- It avoids the embarrassment and potential bias that can be associated with seeing the family doctor.
- The FMU examines confidentially and without judgement.
- The location is more conducive to the patient's privacy when compared with Emergency Department.
- The provision of a counselling service without any pressure on the client may enhance the likelihood of the DV cycle being broken.
- It empowers the client, giving them a voice and validating his/her account.
- There is less stress for the client associated with the court appearance, especially if there is a guilty plea or if the questioning is less intrusive as a result of the quality of the forensic evidence.

The independence of the service was deemed a significant advantage.

> *"Clients can see it's not the cops who are doing it; that's important to some clients as it shows there is a real care factor in the service*

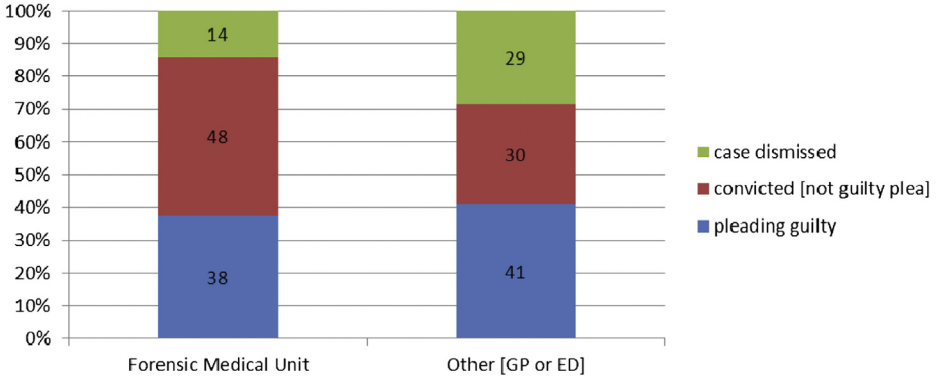

Fig. 2. Case dispositions by type of medical [percentages: 2009–11].

which builds rapport; this makes them more likely to go through with it."

There was broad agreement that the service also substantially benefits police. Brief preparation and, therefore, the quality of evidence is better, especially when compared to that provided by ED and GPs.

"It's invaluable in the way it's presented; it's very thorough. It is my impression that, quite often, that kind of evidence persuades the perpetrator to plead guilty" [police prosecutor].

When asked to identify any problems with the service, most stated that there had been no problems, per se. It was noted that, on occasion, there was some delay with providing the service (due to the fact that it only operated during business hours). There was concern that this would increase the likelihood of some victims not proceeding, as they have more time to change their minds, for example having been influenced by family members or the perpetrators themselves.

"The availability of the service at times that would suit the victim is limited; for example if the incident occurs on Friday night, but the victim can't be seen until Monday. If they have a day or two to think about it, they might change their mind and not proceed".

It was noted that there is a high proportion of socio-economically disadvantaged people in the area serviced who don't have the means to take the requisite action. They may lack transport or the social support needed, for example, to provide childcare while attending medical appointments.

When asked how the service could be improved, police suggested that access could be made easier. This would entail making it more widely available from the geographical perspective and expanding its hours, preferably as a 24/7 service. This would take advantage of the window when people are 'willing to do something'.

"If we could call on behalf of a victim and say 'we'll meet you at the hospital in 20 minutes' we might have a higher take-up rate".

A number of individual suggestions for improving the service were also made. These included:

- Providing better routine information for police to give victims.
- Systematic education for police via training days.

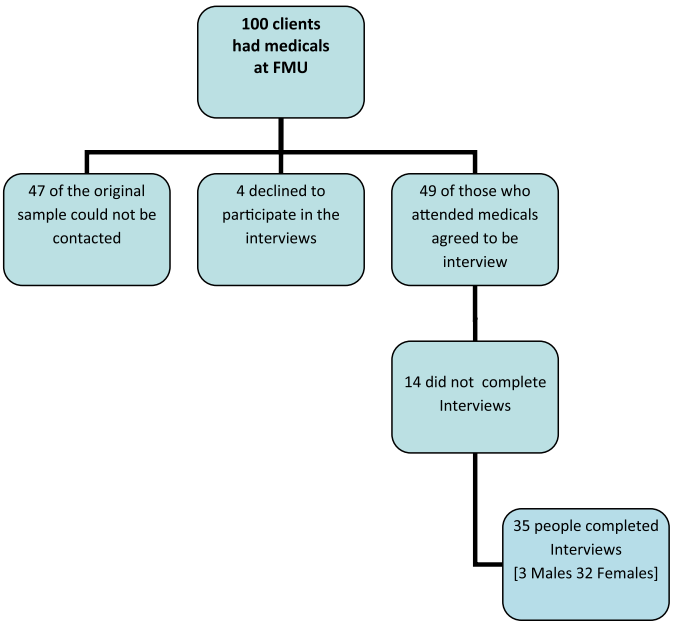

Fig. 4. Participant sample.

- Making it possible for police to pick kits up from Nepean Hospital.
- Extending service provision to victims of physical violence more generally.
- Establishing routine meetings between the services to monitor service provision and to exchange information.

"I estimate around 30% of reported incidents do have actual bodily harm injuries and above. Of these, most would go to the FMU if we were good enough at persuading them or else we could get the FMU to chase them up".

Overall, police interviewees were uniformly positive about the service. They made special note of the professional, approachable and friendly staff and the quality of the service provided.

"It's the best executed pilot I have ever been involved in with the least amount of resources or time spent for the benefit gained".

"The FMU does good work. It is of high quality but I don't see enough of it". [police prosecutor].

5.3. Patient interviews

Although 49 participants initially agreed to undertake the research only 35 completed the interviews [see Fig. 4].

Reasons for not completing questionnaires after original agreement to do so included failure to reconnect with the patient via phone, failure of the patient to return the completed interview when sent out and a few patients, still living in violence, stated that they felt unsafe to participate in the review process. All 35 participants were able to recall attending the forensic medical room and that they received a helpful response from staff.

"They were very understanding and I felt they did not judge me."

Participants' generally positive statements provided a strong indication of their appreciation and the comfort they experienced from the services offered.

When asked whether they thought it had been useful, the majority [32 out of 35] stated they thought it had.

"Yes, when I looked at the pictures they took of me it felt like I was looking at someone else. It had happened so many times but this time I could see it how someone else would see it, abuse".

"It was the first time I ever did anything about the violence. After nearly 40 years of violence it was my 18 year old son who said to me, mum you have to do something about it."

Those less sure about the value of the service were more likely to be still living with violence or else the forensic evidence had been inconclusive. A couple of clients expressed frustration at systems related failures such as instances where evidence was not available at court.

"At court the police could not find the evidence to present".

Rather than describing the services provided by the FMU, some responses highlighted systems failures and challenges. Many women, throughout the interviews, made negative comments about the court system, how powerless they felt in court and how they experienced challenges in accessing other support services. Most were surprisingly philosophical about their experience and spoke about the many things that had gone wrong in the past. The current problems were just part of a recurring pattern. For many of the clients, court did result in convictions and these clients spoke about how vindicated they felt. However, even this was often tainted with shame and guilt. Some participants spoke of the negative experiences, judgements and stereotypes they felt others had around their abuse.

Of those for whom a counselling service had not been provided, the majority [$n = 25$] agreed that a counselling service would have been beneficial.

"Yes, I needed someone to talk to; a counsellor would have been good".

Participants shared different ways in which their lives had changed over time, the majority citing an improvement in their situation. Half spoke of the relationship ending, often associated with a change in living arrangements. Some described changes in their emotional well-being, usually for the better. Others had not fared so well with one respondent alluding to an emerging problem with alcohol, another to being isolated from her family and friends.

A small number of respondents reported that they remained in their relationship and were addressing issues.

"Yes we have fixed a lot of personal problems and we are attending counselling".

Five respondents felt nothing had changed.

Most [$n = 27$] stated they were less fearful. Some respondents were no longer living with violence; some indicated they were stronger or had a sense of greater personal power; others were encouraged by perpetrators' efforts to make some positive changes. However, for some, the trigger to feeling unsafe remained just below the surface with an abiding sense of unease.

Three quarters of the interviewees indicated there had been no further incidents of violence. One stated that, although there had been further violence, this ceased when they moved to different homes. Others identified verbal abuse and harassment. Two described second violent incidents which resulted in a custodial sentence for the offender.

The majority (80%) said they were happy with the evidence provided in court. Many of these cases did not proceed to trial because, in some cases, charges were dropped and in some instances the defendant made a plea. Six made statements to the effect that they were not in court on the day the evidence was shown and discussed.

"It made a lot of difference, it showed me the damage done and it made me see the perpetrator is responsible. I stopped minimising his actions. It made me feel validated".

One sixth of those interviewed thought that the forensic evidence had not helped. Their reasons included that the evidence was not used, not available, not conclusive or did not result in a sentence.

6. Discussion

Prior to the commencement of the Domestic Violence documentation project, victims attended either the ED or a GP for documentation of injuries.

Data indicate that this process of evidence collection can result in positive court outcomes, but there are difficulties.

The process can work well but it is variable. For example, police interviews suggest that some doctors are not practised in documentation of injuries and evidence collection and that the reports are not of a consistently high quality. Attending a family GP can further challenge victims when both the perpetrator of violence and the victim are known to the doctor.

This study found conviction rates tended to be higher for cases where victims attended the FMU as compared to those who attended a doctor in the Emergency Department or a General Practitioner, particularly in circumstances where there had been an initial 'not guilty' plea. The simplest explanation, offered by police and service providers, is that the service offered by the FMU is of superior quality. Other factors may have contributed to the success rate, including the possibility that victims who chose to make an appointment, attend the FMU service and release the information to police may represent a slightly more motivated group of domestic violence victims, at least in terms of taking legal action than those whose medicals were conducted by GPs or ED. The latter group may have comprised victims whose motivations were more likely to include, or even primarily comprise, the seeking of treatment.

Overall and consistent with expectations, clients of the FMU reported feeling safer since taking legal action. However, considerable caution is warranted when considering generalisations about these results. The ample size was small. More importantly, nearly two thirds of the unit's clients could not be interviewed, raising questions about its representativeness. Many of those lost to follow-up, by comparison, may have lives that are more chaotic and more exposed to violence.

Contrary to the widely held perception amongst police that defendants were more likely to plead guilty if the medical had been conducted at the FMU, the proportion of those entering initial guilty pleas was very similar for the two groups. An exploration of the factors that might have contributed to this discrepancy was beyond the scope of the present study. It might be speculated that, unlike prosecutors who were clearly convinced, defendants were in no position to make judgements concerning the differential quality of the two types of medical evidence. Also, practitioner experience suggests that, on occasion, defendants seek to prolong legal proceedings for their own ends, sometimes in the face of clear evidence and even against the legal advice they have received.

Although the service's geographical catchment was limited for the project, the evidence indicates that the model works well and could be expanded to improve a range of service outcomes while providing a more inclusive and holistic health response. The pilot utilised relevant parts of the current Sexual Assault Forensic Medical model and, as such, was relatively easy to implement. Many clients who used the reports at court were clear that the evidence supported them feeling validated and that they were able to justify their claims of abuse formally.

Throughout the course of the study, it became overwhelmingly apparent that there was an underutilisation of the service. Reasons for this are likely to be multifactorial and may include:

- The victim may have met the legal definition of domestic violence but not the project's definition. The legal definition is quite extensive and includes people who reside under the same roof e.g. tenant and landlord.
- The victim may not have had obvious injuries that were able to be documented, either because they were minor, there were no injuries or the injuries were no longer obvious because of the intervening time period.
- Victims were not offered a referral by police.
- Victims were offered a referral, but did not proceed because of disinclination or ambivalence occasioned by disruptions to the referral process, a fear of medico-legal-processes or pressure from a significant other. They may have also faced a host of other barriers such as difficulty in decision-making at times of acute crisis, a sense of powerlessness, a fear of the consequences or a lack of sufficient resources, even access to transport to take the requisite action.

Clearly, complex problems such as these call for suitably multifaceted or multidisciplinary and co-operative responses, well beyond the scope of individual agencies themselves. Nonetheless, since the review a number of practical steps have been taken to address stakeholder recommendations. St Marys and Penrith police now have a page on their Facebook site as well as posters in their command advertising the service to staff and potential victims.

Information now, when completed, is emailed directly to a central email site at either police command, thereby increasing the speed at which the information is delivered and accessible by police. Two new part time nurses have been employed by the FMU which should substantially increase the potential for increasing services both offered and provided by the FMU. Some patients identified the value in having a counsellor present and given the complexity of their current situations it would seem that this would be a valuable addition to the service.

While some victims were not happy with the judicial/police outcome, we acknowledge that not all forensic evidence will be conclusive or result in a conviction (nor should it in some cases). Evidence not being available or used generally related to legal processes rather than deficiencies with the FMU service.

In the course of the review, it became apparent that when people live with violence on a daily basis they often find it difficult to rationally assess the true threat to self. Patients spoke of being strangled, held over balconies, and punched into unconsciousness. It was often in the re-telling of these events, and the independent witnessing of the assault recounts without judgement, that the victim was able to find clarity and to embark on the necessary changes to ensure a safer future.

Forensic Medicine is not currently an Australian Medical Council recognised specialty but it is becoming clearer that high quality forensic documentation and expert opinions can make a difference to court outcomes and patients' ongoing health and safety. Forensic nurses and practitioners have core competencies that can be applied to many medico-legal areas with successful outcomes.

Ethical approval

Approved by NBMLHD Human Research Ethics Committee.

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None.

Conflict of interest

There are no perceived conflict of interests regarding the publication of this article.

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